RECOMMENDATIONS
from
The Ad Hoc Task Force to Address HIV Education, Prevention, Testing and Treatment
to
The HIV Health Services Planning Council, the San Diego County Board of Supervisors, and the San Diego City Council

August 5, 2015

Members of the Ad Hoc Task Force to Address HIV Education, Prevention, Testing and Treatment

Terry Cunningham, Chair - Chair, San Diego County HIV Health Services Planning Council
Patrick Loose, Vice Chair - Chief – HIV, STD and Hepatitis Branch PHS (HSHB)
Dr. Delores Jacobs, Chair – Planning Council Priority Setting Sub-committee
Heidi Aiem – Coordinator – HIV Testing & Counseling Services (HSHB)
Bob Lewis – Dir. of HIV Services, Family Health Centers
Sue Martin – Dir. of HIV Services, Vista Community Clinic
Rosana Scolari – VP of Health Services, San Ysidro Health Center
Mary Caffrey, RN – Director of Mother, Child & Family Services, UCSD
Acintia Wright – African American Community Leader, Consumer
Yvette Ogletree – African American Community Leader, Chair - Consumer Committee
Joe Burke – Chair, Continuum of Care Committee, Consumer
Christian Fuentes – Project MOCHA member
Liz Johnson, Executive Director – Christie's Place

Other Participants

Lauren Brookshire, Assistant Chief HSHB
Lori Jones, HSHB – HIV Prevention HSHB
Stephanie Gioia – Board Aide to Supervisor Ron Roberts
Lindsey Masukawa – Board Aide to Supervisor Dave Roberts
Adriana Martinez – Staff to Councilperson Todd Gloria
Briana Lovett, Planning Council Support Staff
Kenyatta Parker, Planning Council Support Staff
Jaime Rodriguez, Planning Council Support Staff
Prabha Singh, Planning Council Support Staff
Diana Schmidt, AIDS Healthcare Foundation
Julie Hoffman, AIDS Healthcare Foundation
Tara Beeston, Health Educator HSHB
Andrea Fulwiler, Contract Administrator HSHB
Dr. Samantha Tweeten, PhD, County Epidemiologist

Table of Contents

RECOMMENDATIONS
from
The Ad Hoc Task Force to Address HIV Education, Prevention, Testing and Treatment

The United States will become a place where new HIV infections are rare and when they do occur, every person regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic status will have unfettered access to high quality, life-extending care, free from stigma and discrimination.

Vision Statement, National HIV/AIDS Strategy

Executive Summary

At the request of the Chief Administrative Officer, based upon a request by Supervisors Ron Roberts and Dave Roberts, the Ad Hoc Task Force to Address Education, Prevention, Testing and Treatment was formed and began meeting on December 18, 2014. The Ad Hoc Task Force was comprised of members of the HIV Health Services Planning Council who are both providers of services and consumers of services, as well as staff of the HIV, STD and Hepatitis Branch and the HIV/AIDS Epidemiology Unit of Public Health Services. The Task Force met several times to study the existing methods of addressing the HIV epidemic, the epidemiology of HIV in San Diego, and the necessary steps to be taken in order to end this epidemic in the foreseeable future.

The Task Force provided six specific recommendations for ending the epidemic:

1) Develop a media campaign or campaigns to provide general education as well as targeted education to individuals at high risk for infection;

2) Engage private healthcare systems, including independent medical providers treating HIV disease and Medi-Cal managed care plans, to ensure the availability of routine, opt-out HIV testing.
3) Develop action plans for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), two medical interventions that can prevent HIV infection.
4) Implement strategies to utilize surveillance and Ryan White program data to identify individuals who are out of care and bring them into care.
5) Develop and incorporate specific, culturally appropriate strategies for addressing the needs of populations that are disproportionately impacted by HIV;
6) Develop a policy that will focus the County of San Diego, its programs and partners on ending the HIV epidemic over the next decade.

Introduction

On October 31, 2014 a memo from Supervisors Ron Roberts and Dave Roberts was sent to Helen Robbins-Meyer, CAO County of San Diego, requesting the formation of an Ad-Hoc Committee of the HIV Health Services Planning Council. This committee was tasked with the following:

- Gathering and analyzing needs assessment, epidemiological and service utilization data;
- Developing a strategy for engaging with the private and public health care systems; and
- Identifying strategies to reduce fear and stigma, educate the public about HIV, build the capacity of the health care system to deliver PrEP and PEP, ensure routine HIV testing in health care settings, and ensure that those who are HIV positive commence anti-retroviral treatment (ART) immediately.

The Ad Hoc Task Force to Address Education, Prevention, Testing and Treatment began meeting on December 18, 2014.

The Ad Hoc Task Force was comprised of members of the HIV Health Services Planning Council who are both providers of services and consumers of services, as well as staff of the HIV, STD and Hepatitis Branch and the HIV/AIDS Epidemiology Unit of Public Health Services. The Task Force met several times over the past few months to study the existing methods of addressing the HIV epidemic, the epidemiology of HIV in San Diego, and the necessary steps to be taken in order to end this epidemic in the foreseeable future. Of the many areas reviewed by the Ad Hoc Task Force, two overarching themes emerged in all areas: the need for more education and the need for more collaborative efforts.

It is the belief of the Ad Hoc Task Force that the HIV epidemic in San Diego County can be halted. First, it is important to acknowledge the substantial progress that has been made in addressing the HIV epidemic in San Diego County. New diagnoses have declined from the all-time high of 1,314 in 1990 to 478 in 2013, which represents a decrease of 64%. Moreover, deaths among persons living with HIV have declined from an all-time high of 749 in 1994 to 101 in 2013, which represents a decrease of 87%. Nonetheless, as this report will describe, HIV continues to be a major public health threat in San Diego County, with one new HIV diagnosis occurring, on average, every 18 hours.

Recent developments, particularly the Affordable Care Act (ACA) and pre-exposure prophylaxis (PrEP), present opportunities to shift the public health focus from managing the care and treatment of persons living with HIV/AIDS to ending the HIV epidemic. The Task Force found that the current effort to address HIV and AIDS in San Diego County was robust, but that the County nonetheless has fallen behind the United States and California in terms of key indicators of success. However, with some augmentations, presented in the recommendations and discussed throughout this report, San Diego County will be in a better position to achieve the goals of the National HIV/AIDS Strategy.

RECOMMENDATIONS

The following are the final recommendations of the Ad Hoc Task Force. Discussion of the recommendations as well additional key findings can be found in the sections that follow the recommendations.

1) Develop a media campaign or campaigns that addresses one or more of the following components:

    - Increasing broad awareness among the general public that HIV remains a significant health issue impacting the local region;
    - Decreasing stigma related to HIV by normalizing testing, diagnosis and treatment;
    - Availability of HIV testing, including locations and times;
    - Targeting high-risk individuals with health education and risk reduction messages and encouraging HIV testing;
    - Targeting high-risk individuals with specific interventions, including PEP and PrEP; and
    - The importance of commencing HIV treatment immediately and adhering to treatment.

2) Engage private healthcare systems, including independent medical providers treating HIV disease and Medi-Cal managed care plans to

    - Identify and mitigate barriers to the adoption and implementation of routine HIV testing for all adolescents and adults in their healthcare systems;
    - Provide resources for ensuring accepted standards of care as well as HIV treatment guidelines are followed and measured;
    - Provide education about resources available through the Ryan White continuum of care and how to access them; and
    - Provide education about services provided by the County of San Diego, including HIV partner services.

3) Develop action plans for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) with the following components:

    - Educating high-risk HIV negative individuals about PrEP and PEP and linking those interested in the interventions to providers knowledgeable about the interventions;

- Identifying funding sources to create media campaigns targeted toward high-risk populations regarding the availability of these interventions;
- Identifying resources that will support persons in adherence; and
- Identifying resources to develop the capacity of primary care providers for prescribing and monitoring these interventions.

4) Implement strategies to utilize surveillance and Ryan White program data to

   - Re-engage individuals living with HIV/AIDS who are out of care; and
   - Surveillance-based Partner Services.

5) Develop and incorporate specific, culturally appropriate strategies for addressing the needs of the following populations:

   - Women of all ethnicities;
   - Young adults, particularly African American and Latinos;
   - African American and Latino gay, bisexual and other men who have sex with men;
   - Transgender persons;
   - Native Americans; and
   - Gay, bisexual and other men who have sex with men over 50 years of age.

6) Adopt a policy to eliminate or substantially reduce the HIV epidemic over the next decade by addressing some or all of the following components:

   - Convening the medical provider community regarding effective screening, prevention, referral and treatment options that can be implemented within local health care systems;
   - Setting a goal that all San Diego residents be tested for HIV and know their status;
   - Establishing the County of San Diego as an access point for uninsured and underinsured individuals to access PrEP and PEP; and
   - Establishing effective coordination of planning and delivery among the County of San Diego's internal HIV programs.

Overview of HIV in San Diego County

- There are approximately 20,000 persons in San Diego County living with HIV/AIDS.
- Since the beginning of the epidemic, over 7,600 individuals with HIV/AIDS have died.
- On average, someone is newly diagnosed with HIV approximately every 18 hours in San Diego County.
- Half of all individuals newly diagnosed with HIV in San Diego County will receive an AIDS diagnosis within 30 days of their HIV diagnosis, indicating that they were not identified until late in the disease process.
- It is estimated that there are approximately 2,300 individuals living with HIV in San Diego County who are not aware of their HIV status.

- It is further estimated that there are approximately 6,400 individuals living with HIV/AIDS who are aware of their HIV status but are not receiving HIV primary care.

The table below shows the incidence and prevalence of HIV and AIDS for the past three years in San Diego County by the number of cases (County of San Diego Community Epidemiology, July 2014).

	CY 2011		CY 2012		CY 2013	
	Incidence	Prevalence	Incidence	Prevalence	Incidence	Prevalence
HIV	628	4,910	591	5,242	563	5,485
AIDS	525	14,805	441	15,028	458	15,260

In addition to individuals diagnosed within the County, there are many other persons who were diagnosed in other jurisdictions but now reside in San Diego. The table below shows approximately 12,601 people living with HIV (PLWH, not AIDS diagnosed) and 7,459 people living with AIDS (PLWA), for an estimated combined prevalence of 20,060 PLWHA as of December 31, 2013.

AIDS Prevalence and Estimated HIV (not AIDS) Prevalence as of 12/31/13 by Demographic Group and Exposure Category for San Diego County

Demographic Group/ Exposure Category	**2013- PREVALENCE AS OF 12/31/13**			
Race/Ethnicity	**HIV**		**AIDS**	
	#	**%**	**#**	**%**
White, not Hispanic	6,585	52.2	3710	49.7
Black, not Hispanic	1,613	12.8	964	12.9
Hispanic	3,782	30.0	2,497	33.5
Asian/Pacific Islander	455	3.6	218	2.9
American Indian/Alaska Native	89	0.7	47	0.6
Multi-Race	77	0.6	23	0.3
Total	12,601	100	7,459	100
Gender	**HIV**		**AIDS**	
Male	11,379	90.3	6735	90.3
Female	1,222	9.7	724	9.7
Total	12,601	100	7,459	100
Exposure Category	**HIV**		**AIDS**	
Men who have sex with men	9,731	77.5	5,330	71.7

Demographic Group/ Exposure Category	2013- PREVALENCE AS OF 12/31/13			
Injection drug users	556	4.4	586	7.9
Men who have sex with men and inject drugs	742	5.9	690	9.3
Heterosexuals	1,260	10.0	726	9.8
Other/hemophilia/blood transfusion	13	0.1	37*	<0.1
Risk not reported or identified	251	2.0	54**	0.1
Mother with/at risk for HIV	0	0	7	<0.1

This table above includes estimates of persons living with HIV but unaware of their status. It is estimated that approximately 2,372 persons in San Diego County are living with HIV but unaware:

Demographic Group/ Exposure Category	ESTIMATE OF PLWH AND UNAWARE, 2012	
	Estimated number of people living with HIV and not aware of status.	
	Number	Percent of Total
Race/Ethnicity		
Asian/Pacific Islander	126	5.3
Black, not Hispanic	308	13.0
Hispanic	981	41.3
American Indian/Alaskan Native	9	0.4
White, not Hispanic	927	39.1
Multi-Race	21	0.9
Total	**2372**	**100**
Gender		
Male	2135	90.0
Female	237	10.0
Total	**2372**	**100**
Risk Group		
Men who have sex with men	1764	74.4

Injection drug user	121	5.1
Men who have sex with men and inject drugs	88	3.7
Heterosexual	323	13.6
Pediatric	7	0.3
Other/No Identifiable Risk (NIR)	69	2.9
Total	**2372**	**100**

The National HIV/AIDS Strategy (NHAS) and the Cascade of Care

- The National HIV/AIDS Strategy represents the first time that there has been a coordinated federal response for addressing the HIV epidemic.
- The Cascade of Care, also known as the HIV Care Continuum, provides a simple, powerful graphic representation of success in achieving the end of the HIV epidemic.
- Based upon national and state figures, the County of San Diego has fallen behind the U.S. and California in key measures related to ending the HIV epidemic.

In 2010, the White House published the National HIV/AIDS Strategy (NHAS). It was the first time the federal government had developed and deployed a coordinated strategy for addressing HIV and AIDS in the United States. The strategy has four components:

1) Reducing new infections;
2) Increasing access to care in optimizing health outcomes for persons living with HIV;
3) Reducing HIV-related health disparities; and
4) Better coordinating federal resources for addressing the epidemic.

In 2011, the Centers for Disease Control (CDC) analyzed various data sets to assess progress in treating HIV in the United States using a model developed by Dr. Edward Gardner. This model came to be known as the Gardner Cascade and later as the HIV Care Continuum. The cascade provides a visual guide to the number of persons living with HIV and their level of engagement at various points of care:

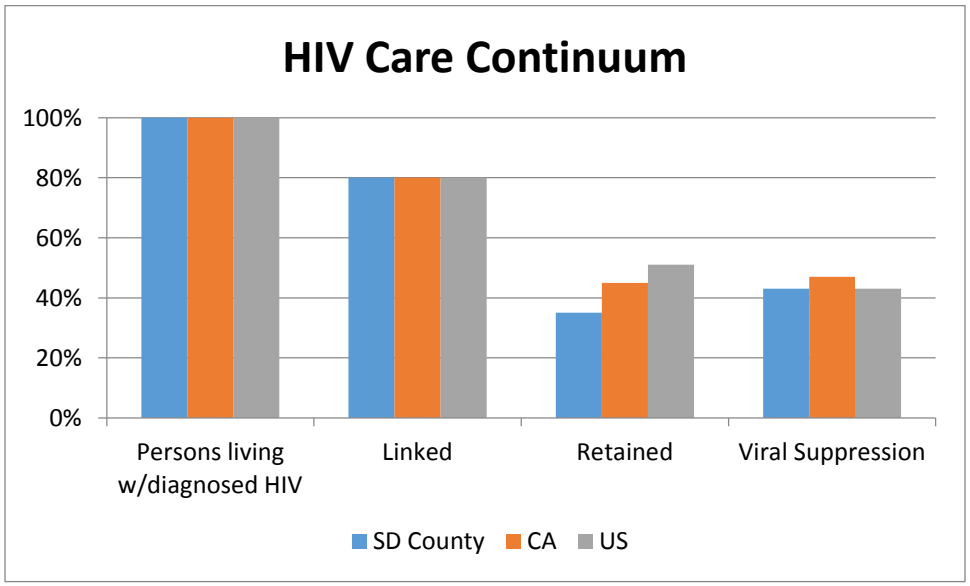
1) **The percentage of persons living with HIV who have been identified.** Early identification of individuals with HIV/AIDS is a crucial component of addressing the epidemic. First, early identification, before significant damage has occurred to the immune system, can lead to better health outcomes and lower overall lifetime treatment costs. Second, once individuals are aware of their status, they can take measures to prevent HIV transmission to others.

2) **The percentage of persons living with HIV who have been linked to HIV primary care.** Once individuals have been identified and informed, the next major step is to connect them to HIV primary care. On this measure, San Diego compares favorably to the State of California as a whole and to the U.S. as a whole, with 4 out of 5 persons newly diagnosed being linked to care.

3) **The percentage of persons living with HIV who have been retained in care.** Once individuals have been referred to care, treatment success depends upon retaining them in care over time. The CDC recently estimated that *90% of all new HIV infections derive from someone who was not in care.* On this measure, San Diego lags behind California and the U.S., with fewer than 4 out of 10 persons living with HIV being successfully retained in care.

4) **The percentage of persons living with HIV who have been prescribed anti-retroviral therapy.** Anti-retroviral treatment, or ART, is the cornerstone of HIV care. Through ART, the amount of HIV present in the blood of someone who is infected (known as "viral load") can be suppressed to the point where it is no longer detectable. While there is an estimate of prescription of ART for the U.S. as a whole, San Diego and California are not able to provide estimates. Therefore, this part of the cascade has not been included in the graphs that are presented below.

5) **The percentage of persons living with HIV who have achieved viral suppression.** When HIV is suppressed, the major health benefit is that the progression of HIV disease in that individual is effectively halted. The major public health benefit is that individuals with suppressed or undetectable viral loads are highly unlikely to transmit HIV to anyone else. As with maintenance in care, San Diego lags behind California and the U.S. in terms of viral suppression. Only a little over 4 out of 10 individuals with HIV in San Diego County are virally suppressed.



Key Findings: Awareness of HIV

- Awareness of HIV has declined significantly since the 1990's when it was identified as one of the most urgent health threats facing the United States.
- The CDC has noted that major forces that contribute to the continuation of the HIV epidemic include low perception of risk, declining health education, and inadequate HIV prevention education.

- Media campaigns, both general and targeted, provide a means for creating awareness, educating the public, and providing targeted messages to individuals at highest risk.

> *In 1995, 44% of the general public indicated that HIV/AIDS was the most urgent health problem facing the nation, compared to only 6% in March 2009. While HIV transmission rates have been reduced substantially over time and people with HIV live longer and more productive lives, approximately 56,000 people become infected each year and more Americans are living with HIV than ever before. Unless we take bold actions, we face a new era of rising infections, greater challenges in serving people living with HIV, and higher health care costs.*
>
> --National HIV/AIDS Strategy

Complacency regarding HIV has been a growing phenomenon for the past decade, and San Diego County is not immune to this trend. The HIV epidemic continues to grow, albeit at a slower rate than what was witnessed in early decades. Funding for general awareness campaigns as well as targeted awareness and risk-reduction media campaigns has diminished significantly.

The Ad Hoc Task Force reviewed media campaigns related to HIV that have been conducted within San Diego County over the past 10 years. Media campaigns targeting HIV have largely been conducted through funding received by the County from the California Department of Public Health, Office of AIDS. The overall purpose of this funding is prevention of new HIV infections. This funding in turn is put into contracts with local providers. Since the 2004-2005 fiscal year, funding for HIV prevention activities has declined from a high of $2 million to a little under $1 million in 2014. As a result of the Great Recession, in 2009 the State Office of AIDS experienced a significant budget cut, and as a result it prohibited the use of its funding for the development of new media campaigns in order for that funding to be preserved for services.

Until 2000, HIV prevention campaigns were largely targeted at those who were HIV negative, focusing on messages and skills building in order to prevent *infection*. Beginning in the early 2000's, however, approximately 25% of HIV prevention efforts began focusing on HIV-positive individuals in order to prevent *transmission*. That transition continued, such that now over 75% of HIV prevention funding received from the Office of AIDS is focused on HIV-positive individuals.

For the past decade, most media campaigns have evolved from relying mostly upon print media (billboards, bus shelters, posters and palm cards) to relying mostly upon electronic media (websites, Facebook and other social media venues).

The Task Force found that media campaigns could address several concerns, including the following:

- Increasing broad awareness among the general public that HIV remains a significant health issue impacting the local region;
- Decreasing stigma related to HIV by normalizing testing, diagnosis and treatment;
- Targeting high-risk individuals with health education and risk reduction messages and encouraging HIV testing;
- Targeting high-risk individuals with specific interventions, including PEP and PrEP.

Key Findings: Treatment as Prevention

- Ensuring that all persons living with HIV remain in continuous care is the most effective form of HIV prevention.
- Numerous barriers prevent many persons living with HIV/AIDS from fully participating in their care; addressing those barriers should be prioritized.
- Up to 6,400 persons living with HIV/AIDS in San Diego County are not currently connected to HIV primary care.
- The CDC estimates that 90% of all new HIV infections come from someone who was not in HIV primary care.

HIV treatment has progressed significantly. One of the key indicators of treatment success is the number of copies of HIV that is detectable in an infected person's blood, known as the "viral load." With consistent treatment, most patients with HIV will achieve a level known as "undetectable." An undetectable viral load has several benefits, including stopping or even reversing damage caused to the immune system as well as increasing positive health outcomes. Another key benefit is that individuals with undetectable viral loads are highly unlikely to transmit the virus to others. In fact, several research studies looking at sero-opposite couples (one partner is HIV-positive and the other HIV-negative) indicate that the risk of transmission is almost non-existent when the HIV-positive partner is virally suppressed.

As a result, one of the key strategies for ending the epidemic is to ensure that all individuals living with HIV/AIDS remain in continuous care. However, numerous barriers prevent persons from fully participating in their care. Within San Diego County, there are approximately 6,400 individuals who are aware of being HIV-positive but who are not receiving HIV primary care. Needs assessment data from the HIV Health Services Planning Council indicate that the most common factors leading someone not to continue HIV primary care include the following:

- Not feeling sick;
- Using drugs or alcohol;
- Not ready to deal with being HIV-positive;
- Fear of stigma and discrimination;
- Mental illness;
- Transportation;
- Other pressing needs, such as childcare; and
- Homelessness.

Most of these factors are being addressed through the local continuum of care that is overseen by the HIV Health Services Planning Council. For instance, "using drugs and alcohol" is addressed through funding allocated to substance abuse treatment. Additional allocations to mental health, transportation, childcare, housing and health education help to address many of the other factors. However, fear of stigma and discrimination remain powerful adversaries, and absent a focused effort to educate the public about the importance of testing and treatment, will likely continue unabated.

The CDC estimates that 90% of all new HIV infections come from someone who is not in HIV primary care. Determining who is out of care and getting them back into care would be highly effective in reducing the epidemic. The CDC developed a protocol for using surveillance data and Ryan White program data to identify individuals who appear to be out of care. Known as the "Data to Care" strategy, it has been highly effective in ensuring that individuals remain in care over time. The Ad Hoc Task Force therefore recommends that the County of San Diego adopt this strategy.

Key Findings: Identifying the Unaware Using Risk-Based vs. Routine HIV Testing

- It is currently estimated that up to 2,300 individuals are infected with HIV in San Diego County who are unaware of their status.
- Approximately half of individuals who are newly diagnosed with HIV will go on to be diagnosed with AIDS within 30 days of their HIV diagnosis, indicating how late in the disease process they are coming into care.
- Free, risk-based HIV testing is widely available in San Diego County.
- The CDC recommended in 2006 that all adults, regardless of risk, be tested for HIV in health care settings.
- In 2013, the U.S. Preventive Services Task Force recommended that all individuals, ages 15 to 65, be screened for HIV in healthcare settings, giving their recommendation a grade of "A"; these recommendations have not been widely adopted by local health care providers.

The HIV/AIDS Epidemiology Unit, using the CDC's estimate of those who are unaware of being infected with HIV, estimates that there are up to 2,300 individuals who are living with HIV but unaware in San Diego County. Further, approximately half of the individuals who are newly diagnosed with HIV will go on to be diagnosed with AIDS within 30 days of their HIV diagnosis (known as "simultaneous diagnosis"). Generally, someone who is infected with HIV will progress to AIDS in around 10 years, absent treatment, indicating how late in the disease process many newly diagnosed individuals are becoming aware of their HIV status.

There are two primary strategies for identifying individuals who are unaware of their HIV status. The first is known as risk-based testing. Through risk-based testing, individuals who are at high-risk for HIV infection are targeted through media campaigns and in-person and online outreach to seek out HIV counseling and testing. In the testing encounter, the patient is provided with counseling: what the test does and does not do, what a positive results means, and what activities the client might be engaging in that places him or her at risk and how those factors can be mitigated. With rapid testing technology, the patient can be informed of his or her result within 20-40 minutes. Risk-based HIV testing has been a cornerstone of public health's response to the HIV epidemic since the first HIV test was made available in 1985. Risk-based HIV testing provided by the County is widely available in most regions of San Diego County.

Risk-based testing, however, has some drawbacks that make it ineffective, by itself, in combatting the epidemic. First, fear and stigma often prevent someone who knows or suspects they are at risk from testing; these individuals worry that testing in and of itself is an admission of engaging in stigmatized behaviors. Second, many individuals who are at risk for HIV are unaware of their risk, and thus messages targeted toward high-risk individuals are lost on them.

The alternative testing strategy is routine, opt-out testing in healthcare settings. Through routine testing, all adolescents and adults receive HIV testing as a routine part of their health care, similar to having their blood pressure or cholesterol checked. Through this process, patients do not need to ask for an HIV test and they do not need to provide written consent for the test. The requirement is that a physician inform the client that they will be tested for HIV and provide them with the option to "opt-out." Routine, opt-out testing has been available in California since 2008, when AB 682 removed the requirement for written consent for HIV testing when conducted by medical providers. Routine, opt-out testing has the potential to identify HIV-positive individuals who are either 1) not a member of one of the major high-risk groups; 2) unaware of their risk; or 3) unwilling to seek out risk-based HIV testing.

In 2006, the Centers for Disease Control and Prevention published "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings." They recommended that all adolescents and adults be tested for HIV in health care settings using a routine, opt-out approach. They further recommended that individuals who are at high risk for HIV infection be tested more frequently, every three to six months. In 2013, the United States Preventive Services Task Force gave a "Grade A" recommendation to routine, opt-out HIV testing. A "Grade A" recommendation is an indication that there is high certainty that the net benefit of routine HIV testing is substantial and well supported by research.

Since 2011, the County of San Diego has used funding from the California Department of Public Health, Office of AIDS to implement routine, opt-out HIV testing in six federally qualified health centers and six of the County's detention facilities. The results of this program have been robust and eye-opening. In 2012 and 2013, the County's routine HIV testing program accounted for approximately 5% percent of all individuals newly diagnosed with HIV. Further, over half of the individuals who were identified as being HIV-positive did not have any identified risk.

The Ad Hoc Task Force found that both risk-based and routine, opt-out HIV testing are best practices for identifying individuals who are living with HIV but unaware of their status. Combined, they are effective in reaching individuals who do not seek HIV testing and can reduce or eliminate barriers due to lack of knowledge, fear and stigma.

Despite its being a best practice, there is no evidence that routine HIV testing has been implemented in any of the major health care systems in San Diego County. This represents a tremendous lost opportunity to identify individuals living with HIV and unaware of their status. Implementation would result in earlier identification of individuals living with HIV, reduction in overall health care costs, a reduction in the ability to infect others, and an overall reduction in the HIV epidemic.

Key Findings: Use of Medication to Prevent HIV Infections in High-Risk Populations

- PrEP and PEP are interventions well supported by research and show great promise in reducing future HIV infections.
- Many persons at risk for HIV infection are unaware of PrEP and PEP as effective interventions for preventing infection or how to access them.

- Many persons who seek PrEP and PEP are unsuccessful without assistance to navigate their health system.
- Many primary care providers are unfamiliar with prescribing guidelines for PrEP and nPEP and are unwilling to prescribe it.
- Success in PrEP often requires additional assistance, such as treatment adherence counseling, which is often unavailable in private and public health care systems.
- Although the medications associated for PrEP and nPEP are covered by most insurance plans, co-pays, co-insurance and deductibles can make it unaffordable for some.

The Ad Hoc Task Force reviewed research in support of the use of certain HIV medications in persons who are HIV-negative to prevent infection from occurring. There are two protocols that address this. The first of these protocols is known as *pre-exposure prophylaxis (PrEP)*, which involves prescribing an HIV medication, Truvada, to HIV-negative individuals who are at high risk for HIV infection. Research on the use of Truvada for PrEP demonstrates that it is up to 99% effective in preventing infection when it is taken daily as prescribed. PrEP has been recommended by the CDC for all individuals who are high risk for HIV infection.

Truvada for PrEP is covered through a variety of health care plans, including Medi-Cal and private plans offered through Covered California. However, under private health plans, Truvada might have a monthly co-payment as high as $250. Additionally, not all medical providers are aware of PrEP or even how to access it within their own healthcare systems. Finally, many patients have reported being denied PrEP by their providers due to the provider's insistence on behavior change. Obtaining PrEP can often involve multiple visits to different providers and labs; many patients, without navigation assistance, will not be successful in obtaining PrEP.

The second protocol is known as *non-occupational post-exposure prophylaxis (PEP)*, which involves prescribing a 30-day HIV medication regimen to individuals who have had high-risk exposures to HIV within the prior 72 hours. The same protocols are used as the ones to treat medical professionals who have accidental, high-risk exposures to HIV. These protocols were first described by the CDC in 2001 and updated in 2013.

The Ad Hoc Task Force found both practices to be well supported by research and recommends that the County implement programs to address both.

Key Findings: The Impact of the Affordable Care Act (ACA) on HIV Care

The Affordable Care Act has had a significant impact on the local continuum of care. Because of the implementation of Covered California and Expanded Medi-Cal, many persons living with HIV who relied upon Ryan White for access to primary care and medication now have access to those services through other means. This shift in payers has created significant savings in the local Ryan White program that have been re-purposed to increase access to core services that promote retention in care; these include psychiatric services, mental health services and medical case management. Overall, there has been a 70% reduction in the number of patients enrolled in the Ryan White Primary Care program, from a high of approximate 3,500 to around 1,000 as of this report's writing.

The implementation of the ACA has not been without its downsides. First, transitioning care from one system to another has proven disruptive for many clients. With regard to the Medi-Cal transition, many patients were automatically assigned to primary care physicians or plans based upon their zip code of residence; as a result, they were assigned to physicians who were not experienced in treating HIV. Fortunately, assigning them to a plan or to an experienced physician could usually be accomplished in less than a month. For patients who enrolled in Covered California, many were not aware of the financial impacts of their choice of plan or level of plan. Those who chose bronze plans found themselves responsible for significant out-of-pocket expenses stemming from deductibles, co-payments and co-insurance. However, as patients and certified enrollment entities gain more experience, they will be better able to make choices that reduce factors that could disrupt care.

There are additional issues that could result in patients not receiving all the support they need to remain in care and thus falling out of care. The first of these issues is that the Ryan White continuum of care was a single system, with a consistent set of eligibility and access requirements and the ability to access any part of the continuum from any other part (for instance, accessing child care to support attendance at medical appointments). However, as patients begin to receive primary medical care, mental health and psychiatric services from different systems, many persons living with HIV will now be responsible for coordinating their own care among those different systems. Moreover, many of the larger healthcare systems have not routinely interacted with the Ryan White continuum of care and have little knowledge about the resources available or how to access them.

Key Findings: Disproportionalities

During the review by the Ad Hoc Task Force of the reports from the San Diego HIV Epidemiology Unit, there emerged a picture of disproportionality among various ages, races and sexual orientations represented in the HIV/AIDS data presented. African Americans and Latinos have the first and second highest rates, respectively. African Americans and Native Americans are more likely to be out of care than other groups. Latinos progress faster from HIV to AIDS and from AIDS to death than any other group. Women experience different barriers to accessing and remaining in care.

As result of these finding, the Task Force recommends that the County incorporate specific strategies for addressing the needs of the following populations:

- Women of all ethnicities;
- Young adults, particularly African American and Latino;
- African American and Latino gay, bisexual and other men who have sex with men;
- Transgender persons;
- Native Americans; and
- Gay, bisexual and other men who have sex with men and are over 50 years of age.

Key Findings: Ending the HIV Epidemic

The CDC has established "winnable battles," which are "health priorities with large-scale impact on health and known effective strategies to address them." HIV in the U.S. is one of those winnable battles. The tools to dramatically reduce the number of new HIV infections—testing, treatment, prevention—already exist. But they are not fully implemented, and they are not strategically coordinated with the goal of ending the epidemic. What is necessary is commitment to ending the epidemic and convening public and private resources to reach this audacious goal.

By establishing the goal of ending the epidemic as policy, the Board of Supervisors and other local governments would greatly focus efforts in San Diego County. Specific activities related to this policy could include:

- Convening the medical provider community regarding effective testing, treatment, and prevention options that can be accessed and/or implemented within local health care systems;
- Setting a goal that all San Diego residents be tested for HIV and know their status;
- Establishing the County of San Diego as an access point for uninsured and underinsured individuals to access PrEP and PEP; and
- Establishing effective coordination of planning and delivery among the County of San Diego's internal HIV programs.

Conclusions

While the recommendations in this report appear to be numerous and complex, all of the activities can be accomplished with the buy in of the medical community in San Diego County. We have the ability to end this epidemic here in the foreseeable future. It will take a collaborative effort, combining resources from a wide arena. This is not a unique situation. All major metropolitan areas in the United States are facing the same daunting task. However, the consequences of not engaging in a coordinated effort to stop the spread of HIV disease will be dire, unless a cure or vaccine is developed. Both a cure and a vaccine have been alluded to over the past thirty years as being only 10 years away. Unfortunately, these two scientific achievements have been superseded in great part by the quest for medical interventions to decrease the ability of the virus to reproduce in the body. The changes in the healthcare system in the United States have created a system where more individuals will be able to receive more care. These changes also present challenges that must be addressed in order for those with a controllable chronic contagious disease such as HIV/AIDS be maintained in care to keep the virus in their systems at a level that will not lead to infection of others. This can be accomplished by educating citizens of the need to be tested for HIV at all opportunities, to enter into medical treatment and to continue medical treatment for the length of their lives. In order to halt the spread of this epidemic this message must be constantly reinforced by all medical providers.